

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 005729	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 07/26/2013
NAME OF PROVIDER OR SUPPLIER CROWNPOINTE OF INDIANAPOLIS		STREET ADDRESS, CITY, STATE, ZIP CODE 7365 E 16TH ST INDIANAPOLIS, IN 46219		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 000	<p>INITIAL COMMENTS</p> <p>This visit was for the Investigation of Complaint IN00132847.</p> <p>Complaint IN00132847 substantiated. No deficiencies related to the allegation are cited.</p> <p>Survey Date: July 26 2013</p> <p>Facility number: 005729 Provider number: 005729 AIM number: NA</p> <p>Survey team: Chuck Stevenson RN</p> <p>Census bed type: Residential: 65 Total: 65</p> <p>Census payor type: Medicaid: 59 Other: 6 Total: 65</p> <p>Sample: NA</p> <p>Crownpointe of Indianapolis was found to be in compliance with 410 IAC 16.2 in regard to the Investigation of Complaint IN00132847.</p> <p>Quality Review 07/26/13 by Lisa McColly</p>	R 000		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE